Informed Consent For Participation in *Kentucky Transitions – Money Follows the Person (MFP) Rebalancing Demonstration*

Completion of this form is voluntary. Failure to complete will mean that the individual cannot participate in *Kentucky Transitions*.

Participant Name:	Social Security Number

I have been informed that:

- Kentucky Transitions is sponsored by the federal Centers for Medicare and Medicaid (CMS). The demonstration will support states to rebalance their long-term care system, transition eligible individuals from institutions, and improve the long-term care system overall.
- CMS has awarded a demonstration grant to the Kentucky Department for Medicaid Services to operate *Kentucky Transitions*.
- CMS has contracted with Mathematica Policy Research to evaluate the MFP demonstration project nationwide. Certain information about MFP demonstration participants will be shared with CMS and with Mathematica Policy Research in order to meet the statutory requirement to evaluate the MFP Demonstration.
- Participation in *Kentucky Transitions* is completely voluntary.
- Refusal to participate in *Kentucky Transitions* will not affect my eligibility for Medicaid or home and community-based services.

Benefits of Kentucky Transitions Potential benefits from my participation in *Kentucky Transitions* include the following:

- I will be offered services under *Kentucky Transitions* to enable me to transition from the institution in which I live to a home, apartment, or small group living setting in the community. *Kentucky Transitions* demonstration services will continue for one year as long as I continue to meet the eligibility requirements for the program.
- At the end of one year, I will continue to receive services under the home and community-based program as long as I continue to meet the eligibility requirements for the program.

Potential Risk

- There is a slight risk that there would be unauthorized release of confidential information. The risk of unauthorized release of data is judged low because of the procedures in place to protect data and to limit its release to other parties (as described below).
- There is also a risk that I may lose some services at the end of the transition year. The community-based program may not offer all the services needed at the same frequency or level.

Participation in Research

- Information about my participation in *Kentucky Transitions* will be provided to CMS and to Mathematica Policy Research, the evaluation contractor authorized by CMS.
- I may be asked to respond to surveys, participate in visits to my home or otherwise communicate with the evaluation contractor for the MFP Demonstration.

I have been provided the opportunity to read material describing the research component of the MFP Demonstration. This material describes the basic goals of the research, the types of data that will be collected, how the confidentiality of data is protected, the likely benefits and risks associated with the research, and who I can contact if I have any questions about the research material.

Confidentiality

I have been informed that the information provided by the Kentucky Department for Medicaid Services to CMS and the evaluation contractor is confidential and will be protected under the Health Insurance Portability and Accountability Act (HIPAA).

Withdrawal from the Project

My participation in *Kentucky Transitions* is entirely voluntary. If I enroll in Kentucky Transitions, I may withdraw at any time by completing a withdrawal form. I can get the withdrawal form from my Transition Specialist or from the *Kentucky Transitions* Project Director.

Emergency Contact Information

I have been provided with written information on the steps to take in the event of a non-medical emergency related to my care (i.e., the worker does not show up, equipment failure).

Complaints

I understand that if I have any complaints or concerns about my participation in *Kentucky Transitions*, I can contact the MFP Transition Team at [502-564-7540].
I also understand that I have certain rights to file a grievance or appeal a decision as a Medicaid waiver participant. The Transition Specialist has provided me with information regarding my rights and responsibilities as a Medicaid waiver participant and has provided me with information regarding the process to file a grievance or appeal.

Consent
My Transition Specialist explained to my rights and responsibilities under *Kentucky Transitions*. I understand that I will be given a signed copy of this consent form to keep. If I have questions about the operational and benefit aspects of Kentucky Transitions that cannot be answered by my Transition Specialist, I can contact the MFP Transition Team at [502-564-7540].

By signing this Informed Consent, I am agreeing to participate in *Kentucky Transitions* and to accept all conditions for participation.

A copy of this form is as valid as an original.

_____	_____	_____
Participant Printed Name	Participant Signature	Date
_____	_____	_____
Legally Authorized Representative Printed Name	Legally Authorized Representative Signature	Date

Transition Specialist Acknowledgement
I have explained the purposes and limits of the project and the services that may be available through Kentucky Transitions. I have also explained what is expected of an individual who decides to participate in the project. I have answered all questions about the project asked by the person listed above and by their Legally Authorized Representative, when one exists. I hereby witness the above signatures and I believe that he/she (and the legally authorized representative, if signed) understands the materials.

_____	_____	_____
Transition Specialist Printed Name	Transition Specialist Signature	Date

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Option to Formally Decline Participation

I was offered the opportunity to participate in *Kentucky Transitions* and have chosen to **decline**. I understand that this will not affect my eligibility for Medicaid or home and community-based services.

_____	_____	_____
Participant Printed Name	Participant Signature	Date
_____	_____	_____
Legally Authorized Representative Printed Name	Legally Authorized Representative Signature	Date